

PATIENT INFORMATION

Office of Dr. L. Warren West
**** PLEASE PRINT CLEARLY ****

TODAYS DATE: _____

PATIENT NAME: _____ SEX: M / F BIRTHDATE: _____

ADDRESS: _____

(must include street address with all post office boxes) CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____ WORK PHONE: () _____ CELL/BEEPER: () _____

PATIENT SOCIAL SECURITY NUMBER: _____ REFERRED BY: _____

PHYSICIAN NAME: _____ DENTIST NAME: _____ PHARMACY: _____

EMPLOYER NAME(parent if minor): _____ PATIENT SCHOOL NAME (if student) _____

PARENT/GUARDIAN NAME (if minor): _____ SOCIAL SECURITY #: _____

PARENT HOME PHONE: () _____ PARENT DOB: _____ SEX: M / F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PARENT/GUARDIAN EMPLOYER NAME: _____ WORK PHONE: () _____

INSURANCE INFORMATION: (Please give secretary your insurance card to copy)-information must be given at time of appointment in order to file this for you. **Patients requiring referrals are responsible for providing them at time of service.**

NAME OF INSURANCE:

MEDICAL: _____ NAME OF POLICYHOLDER: _____ DOB: _____ SS# _____

DENTAL: _____ NAME OF POLICYHOLDER: _____ DOB: _____ SS# _____

SECONDARY?: _____ NAME OF POLICYHOLDER: _____ DOB: _____ SS# _____

Is the responsible party a member of the military? Yes _____ Branch _____ No _____

I AUTHORIZE THE OFFICE OF DR. L. WARREN WEST TO FILE ANY INSURANCE ON MY BEHALF AND TO PROVIDE ANY MEDICAL INFORMATION NECESSARY TO THE APPROPRIATE PERSONS FOR MY MEDICAL & FINANCIAL NEEDS:

Signature: _____ Todays Date: _____ Update Date: _____

COPY OF INSURANCE CARD (front and back)